PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES I OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G806	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 31/2012
	PROVIDER OR SUPPLIE		1441 W	ADDRESS, CITY, STATE, ZIP CO VOODLAWN ITH, IN 46319	DDE	
				1111, 114 40010		1 215
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH		(X5)
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W0000	REGULATORT OF	X LSC IDENTIFT ING INFORMATION)	TAG			DATE
			W0000			
	This wisit was for	or a fundamental	***************************************			
	recertification a	nd state licensure suvey.				
	Dates of survey	: August 28, 29, 30 and				
	31, 2012	. August 20, 27, 30 and				
	31, 2012					
	Facility number	·· 012713				
	Provider number					
	AIM number: 1					
	All Hulliber. 1	00233340				
	Surveyor: Chris	stine Colon, Medical				
	Surveyor III/QN					
	Burveyor III/QI	AINI				
	The following d	leficiencies also reflect				
	1	accordance with 460 IAC				
	1	accordance with 400 IAC				
	9.					
	Quality Review	was completed on 9/7/12				
	1 '	Medical Surveyor III.				
	by Tilli Shebel,	wiedicai Suiveyoi III.				
			1			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	N OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
	15G806	B. WING		08/31/2012
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIER	1441 V	VOODLAWN	
ARC OF	NORTHWEST INDIANA INC, THE	GRIFF	ITH, IN 46319	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR	E COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must			
	be integrated, coordinated and monitored by a qualified mental retardation professional.			
	a qualified mental retardation professional.	W0159	Service Coordinator will revi	ew 09/20/2012
	Based on record review and interview the facility failed to assure clients programs were monitored in regards to timely revisions for 1 or 3 sampled clients (client #3), and failed to assure active treatment objectives for 3 of 3 sampled clients (clients #1, #2 and #3) were monitored by the Qualified Mental Retardation	W0139	and submit progress notes monthly for all clients. To en future compliance, Individual Program Coordinator will mound individual Program plan files monthly to ensure document is provided and reviewed in timely manner.	sure I onitor tation
	Professional (QMRP).			
	Findings include:			
	A review of client #1's record was conducted at the facility's administrative office on 8/29/12 at 12:10 P.M Review of client #1's Individual Support Plan (ISP) dated 5/16/12 indicated the following: "Will continue to learn to stay on taskwill continue to learn his address and street namewill independently make a purchase using 5 single dollar billswill learn to print his address using a samplewill learn to match items by putting them away where they belongWill use his communication book to express his wants and needswill socialize with his peers by participating in			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G806	(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 08/31	ETED
	PROVIDER OR SUPPLIER		ı	1441 W	DDRESS, CITY, STATE, ZIP CODE OODLAWN FH, IN 46319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	about his medical learn to brush his client #1's active "Progress Note Smonthly review months of June 2"  A review of client conducted at the office on 8/29/12 of client #2's Ind (ISP) dated 9/15 following: "Will medicationswill informationwill the gym once a relearn to make puridentify the address homewill control of his personal be make sugar free brush his teeth at communicate be vocabulary beyo responseswill smeals according foodwill use the gym." A review treatment objection sugar sugar free brush his teeth at communicate be vocabulary beyo responseswill smeals according foodwill use the gym." A review treatment objection sugar free brush his teeth at communicate be vocabulary beyo responseswill smeals according foodwill use the gym." A review treatment objection sugar free brush will use the gym." A review treatment objection sugar free brush will use the gym." A review treatment objection sugar free brush will use the gym." A review treatment objection sugar free brush will use the gym." A review treatment objection sugar free brush will use the gym." A review treatment objection sugar free brush will use the gym." A review treatment objection sugar free brush will use the gym." A review treatment objection sugar free brush will use the gym."	I learn about his Il learn diabetes Il use the exercise bike in monthwill continue to rchaseswill verbally ess of his group inue to learn to take care edroomwill learn to snackswill learn to fter eatingwill learn to tter by expanding his nd one word serve himself during					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY  COMPLETED	
ANDILLAN	OI CORRECTION	15G806		LDING	00	08/31/	
		100000	B. WIN		A PARAGO CHARL COM	00/01/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			OODLAWN TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nt #3's record was					
		facility's administrative					
		2 at 1:10 P.M Review					
		ividual Support Plan					
	(ISP) dated 5/11						
		l continue to learn to					
		ene checklistwill					
		diabetic medications and					
	_	nptomswill continue to					
	_	is physicians and					
		ointmentswill learn to					
	· ·	gar free dessertswill					
		s teeth dailywill					
		to stay focused on work					
		the material handling job					
		down time he will learn					
		10will learn to brush					
	-	ter lunch." A review of					
		treatment objective					
	_	Summary" indicated no					
	monthly review	by a QMRP for the					
	months of June 2	2012 and July 2012.					
		f the record failed to					
	indicate client #3	3 had a more current ISP.					
	An interview with	th the Service					
	`	/QMRP) was conducted					
	on 8/31/12 at 11:	:45 A.M The SC					
	indicated clients'	active treatment					
	objectives should	d be reviewed monthly					
	and entered into	the data base					
	immediately afte	er review of the objectives					
	to monitor progr	ess or regression. The					
	SC further indica	ated client #3's ISP was					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G806	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM	TE SURVEY  SPLETED  31/2012
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	1441 W	ADDRESS, CITY, STATE, ZIP ( /OODLAWN TH, IN 46319	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the most current available. There was no documentation submitted for review to indicate the QMRP monitored each clients active treatment objectives or his ISP had been reviewed annually.  9-3-3(a)				

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	OF CORRECTION  OF CORRECTION  15G806	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/31/2012
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	1441 W	ADDRESS, CITY, STATE, ZIP CODE /OODLAWN ITH, IN 46319	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W0192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.  Based on observation, record review and interview, the facility failed for 5 of 5 clients observed during medication administration (clients #1, #2, #3, #4 and #5) by staff not demonstrating skills and competency to administer medications as prescribed.  Findings include:  A morning observation was conducted at the group home on 8/28/12 from 5:40 A.M. until 8:15 A.M At 6:40 A.M., client #2 received his morning prescribed medications. Direct Support Professional (DSP) #1 administered his "Levothyroxine 50 mcg (microgram) tablet (thyroid)1 tablet orally once a dayTake with plenty of waterGlimepiride 1 mg (milligram) tablet (high blood sugar)1/2 tablet (.5 mg) orally once a dayTake with first meal of the day." Client #2 took a sip of water. Client #2 did not take his medication with plenty of water. Client #2 ate breakfast at 7:50 A.M Client #2 did	W0192	Service Coordinator and/or Community Services Nurse w train staff on proper medication administration focusing on following prescribed orders for each medication. To ensure future compliance, Community Services Nurse and/or Services Coordinator will observe medication administration at least monthly thereafter.	r y e east

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	OF CORRECTION  IDENTIFICATION NUMBER:  15G806	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY MPLETED 31/2012
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	1441 W	ADDRESS, CITY, STATE, ZIP ( OODLAWN TH, IN 46319	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	not take his medication with his first meal of the day.				
	At 6:45 A.M., client #1 received his morning medications. DSP #1 administered his "Nabumetone 750 mg tablet (arthritis)Take with plenty of waterTake with foodDocusate Sodium 100 mg capsule (stool softener)Take with plenty of water." Client #1 took a sip of water. Client #2 did not take his medication with food and did not drink plenty of water during this medication administration.  At 6:50 A.M., client #4 received his morning medications. DSP #1				
	administered client #4's "Klor-con 10 meq tablet (potassium)Take with plenty of waterThera M Tablet (supplement) tabletTake with plenty of water." Client #4 took a sip of water. Client #4 did not take his medications with plenty of water during this medication administration.  At 6:55 A.M., client #3 received his morning medications. DSP #1 administered client #3's "Metformin 850 mg tablet (diabetes)Take with plenty of waterTake with food/mealThera M				
	Tablet (supplement) tabletTake with plenty of waterGlimepiride 4 mg tablet (diabetes)Take with first meal of the dayLithium Carbonate 300 mg capsule				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			Ì		NSTRUCTION 00	(X3) DATE S COMPL	
		15G806	A. BUILI B. WING		<del></del>	08/31/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	ANA INC, THE			OODLAWN ГН, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	(bipolar)Take						
		h food/meal." Client #3 er. Client #4 did not take					
	-	with plenty of water or					
		luring this medication					
	administration.						
	At 7:00 A.M., cl	ient #5 received his					
	morning medica						
		ent #5's "Celebrex 200 ritis)Take with					
		nt #5 did not take his					
		n food/meal during this					
	medication admi	nistration.					
	An interview wi	th the nurse was					
		31/12 at 11:20 A.M The					
		staff should administer all rescribed. The nurse					
	-	staff should follow					
	directions on me	dication labels on					
	medication pack	ets.					
	9-3-3(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G806	B. WING	_	08/31/2012	
NAME OF B	DDOVIDED OD CLIDDLIEI		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		1441 V	VOODLAWN		
	NORTHWEST IND	·	GRIFFITH, IN 46319			
(X4) ID		TATEMENT OF DEFICIENCIES	ID  PROVIDER'S PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIAT  DEFICIENCY  DEFICIENCY		(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL				
		CLSC IDENTIFYING INFORMATION)	IAG	DETERMET)	DATE	
TAG W0248	483.440(c)(7) INDIVIDUAL PRO A copy of each composed be made available including staff of with the client, and the client is a minus of the client	lient's individual plan must le to all relevant staff, other agencies who work and to the client, parents (if nor) or legal guardian.  Treview and interview, the have updated Individual SP) for 5 of 5 clients roup home (clients #1, #2, available for all staff who roup home.	W0248	Individual Program Coordinate will complete ISP within the required time frame and provide the documentation to each group home following the scheduled for each client. To ensure futue compliance, the Service Coordinator will monitor the clifiles at the group home at least bi-monthly to ensure all documentation is present and current.	or 09/20/2012 de pup IDT re	
	Interview with I	Direct Service SP) #1 was conducted on				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPL	
		15G806	B. WING			08/31/	2012
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIO TUE			OODLAWN		
ARC OF	NORTHWEST IND	IANA INC, THE		GRIFFI	TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGENCI		DATE
		P.M. DSP #1 indicated					
	client #1, #2, #3, #4 and #5's most current ISPs were not available for the group home staff.  A review of client #1's record was						
		facility's administrative					
		2 at 12:10 P.M The a most current ISP dated					
	5/16/12.	a most current ISP dated					
	3/10/12.						
	A ravious of alia	nt #2's record was					
		facility's administrative					
		2 at 12:40 P.M The					
		a most current ISP dated					
	9/15/11.	a most current 15F dated					
	9/13/11.						
	Δ review of clie	nt #3's record was					
		facility's administrative					
		2 at 1:10 P.M The					
		a most current ISP dated					
	5/11/11.	a most current isi dated					
	J/11/11.						
	A review of clie	nt #4's record was					
		facility's administrative					
		2 at 1:35 P.M The					
		a most current ISP dated					
	5/3/12.	a most current 151 dated					
	J/J/12.						
	A review of clie	nt #5's record was					
		facility's administrative					
		2 at 1:50 P.M The					
		a most current ISP dated					
	5/7/12.	a most current 151 uateu					
	5/ // 12.						

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	OF CORRECTION  IDENTIFICATION NUMBER:  15G806	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	— COM 08/3	TE SURVEY PLETED 81/2012
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE  1441 WOODLAWN GRIFFITH, IN 46319			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	An interview with the Service Coordinator (SC) was conducted on 8/31/12 at 11:40 A.M The SC indicated the group home staff should have updated ISPs for clients #1, #2, #3, #4 and #5. 9-3-4(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G806		(X2) MU A. BUII B. WIN	DING	ONSTRUCTION  00	(X3) DATE COMPL 08/31/	ETED	
	PROVIDER OR SUPPLIER		J. WII.	STREET A	ADDRESS, CITY, STATE, ZIP CODE COODLAWN TH, IN 46319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0249	formulated a clier each client must a treatment prograr interventions and number and frequachievement of the individual program interview, the factories witten objective opportunity for 3 (clients #1, #2 and Findings include A morning observation period at in the living a Professional (DS walk through and clients #1, #2 and meaningful active implement clients A review of clients at the office on 8/29/12	terdisciplinary team has nt's individual program plan, receive a continuous active in consisting of needed services in sufficient uency to support the ne objectives identified in gram plan.  ation, record review, and cility failed to implement es during times of 3 sampled clients and #3).  Exercise the services in sufficient in gram plan.  The services in sufficient in gram plan.  The services identified in gram plan.  The services in sufficient in gram plan.  The se	W02	249	Service Coordinator will retrain staff on providing active treatm to each client. Service Coordinator will focus on asper of learning opportunities as we as scheduled objectives. To ensure future compliance, the Service Coordinator will monities the completion of the ISP for each client within ten days of the scheduled IDT. 9/28/12  The Individual Program Coordinator will develop the ISP within 10 days of the IDT. The Service Coordinator will then ensure that all staff are trained on this ISP and that the document is available at the group home within 10 days of its completion. On a monthly basis the Lead Service Coordinator will monitor the completion of training in comparison with the date of each client's annual. This will ensure that staff are trained and that the ISPs and new objectives are in place.	nent ects ell or the	09/20/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		15G806	B. WIN			08/31/2	012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
					OODLAWN		
ARC OF	NORTHWEST IND	IANA INC, THE		GRIFFI	ΓH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re '	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	` '	/12 indicated the					
		l continue to learn to stay					
		ntinue to learn his address					
		will independently make					
	a purchase using 5 single dollar billswill learn to print his address using a samplewill learn to match items by putting them away where they belongWill use his communication book to express his wants and needswill socialize with his peers by participating in						
	group activityv	will continue to learn					
	about his medica	ations."					
	A review of clie	nt #2's record was					
	conducted at the	facility's administrative					
		2 at 12:40 P.M Review					
		lividual Support Plan					
	(ISP) dated 9/15						
	following: "Wil						
	medicationswi						
		Il use the exercise bike in					
		nonthwill continue to					
	1	rchaseswill verbally					
	identify the addr	·					
	1 -	inue to learn to take care					
	_	edroomwill learn to					
		snackswill learn to					
		tter by expanding his					
	vocabulary beyo						
	responseswill serve himself during meals according to placement of food."						
	A review of clie	nt #3's record was					

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	PROVIDER OR SUPPLIER		STRE 1441	et address, city, state, zi I WOODLAWN FFITH, IN 46319	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	office on 8/29/12 of client #3's Ind (ISP) dated 5/11. following: "Wil complete a hygic continue to learn the signs and syr follow-up with h psychiatrist apporable healthy suglearn to brush his continue to learn taskswill learn in which during how to count to  The Service Cool interviewed on 8 The SC stated climplemented "du opportunity." The clients #1, #2 and provided with m	I continue to learn to ene checklistwill diabetic medications and enptomswill continue to is physicians and eintmentswill learn to gar free dessertswill steeth dailywill to stay focused on work the material handling job down time he will learn 10."  Indicator (SC) was /31/12 at 11:20 A.M ient objectives should be uring times of the SC further indicated d #3 should have been eaningful active ies during the morning				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED		
		15G806	A. BUILDING	<del></del>	08/31/2012		
			B. WING	ADDRESS CITY STATE TIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE			
ADC OF	NODTUMEST INF	NAMA INC. THE	1441 WOODLAWN GRIFFITH, IN 46319				
ARC OF	NORTHWEST INC	DIANA INC, THE	GRIFFI	11H, IN 46319			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
W0260	483.440(f)(2) PROGRAM MODA t least annually must be revised the process set is section.  Based on record 1 of 3 sampled Service Coordin Retardation Profailed to revise Plan (ISP) with previous ISP.  Findings includ A review of clie conducted on 8/43's record indidated 5/11/11. a more recent side An interview we conducted on 8/5C indicated ear	NITORING & CHANGE  If, the individual program plan If, as appropriate, repeating forth in paragraph (c) of this  If review and interview for clients (client #3), the nator/Qualified Mental If ressional (SC/QMRP) Itheir Individual Support In 365 days of the  e:  There was no evidence of Igned and dated ISP.  Ith the SC/QMRP was If you was I	W0260	The Individual Program Coordinator will complete ISP all clients within the required timeline. To ensure future compliance, the Service Coordinator will monitor the completion of the ISP for each client within ten days of the scheduled IDT.	s for		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G806	B. WING			08/31/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OODLAWN		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0436	483.470(g)(2) SPACE AND EQI The facility must to repair, and teach informed choices eyeglasses, heard communications and devices identified team as needed to be assed on observinterview, the face eyeglasses for 1	UIPMENT furnish, maintain in good clients to use and to make about the use of dentures, ing and other aids, braces, and other by the interdisciplinary by the client.  ation, record review, and cility failed to provide of 3 sampled clients equired eyeglasses.	W04		The Health Care Managers, Community Services Nurse, and/or Service Coordinator wil report all adaptive equipment breakage and send in any brol adaptive equipment to the appropriate repair center within twenty four hours of receipt. For wheelchair breakage Service Coordinator will contact the appropriate agency to report a	ken n or	09/20/2012
	the group home of A.M. until 8:15 A observation period prescribed eyeglaction #3 asked I Professional (DS to get his eyeglated don't know."  A review of the fraction on 8/28/12 at 3:4 reports indicated Incident report desired the second sec	SP) #1 when he was going sses. DSP #1 stated "I facility's internal treports was conducted to P.M Review of the			schedule repair. To ensure futicompliance, Service Coordinate and/or Community Services Nurse will monitor adaptive equipment at least bi-monthly damage and needed repairs. Service Coordinator, Health Camangers, and/or Community Services Nurse will continue follow up until repairs are completed and adaptive equipment is returned to the client.9/28/12 Client #1 received his repaired glasses on 9/21/12. Client #2 received his repaired glasses on 9/24/12. Staff will monitor appropriate placement of Client #1 and all other clients twice daily and have been trained on reporting damaged adaptive equipment in a	tors	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G806	B. WING		08/31/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
<b>∆ P C C E</b>	NORTHWEST IND	IANA INC. THE		VOODLAWN ITH, IN 46319	
		·		11 H, IN 403 19	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
		ell apart. The glasses		timely manner.	
	ر ،	oke, they just had glue and		,	
	tape keeping the				
	An evening obse	ervation was conducted at			
	the group home on 8/28/12 from 5:30				
	P.M. until 7:40 I	P.M During the entire			
	observation perio	od, client #3 did not wear			
	prescribed eyegl				
	A facility owned day program observation				
	was conducted o	on 8/30/12 from 1:25 P.M.			
	until 2:30 P.M	During the observation			
	period client #3	did not wear prescribed			
	eyeglasses.				
		d was reviewed on			
		P.M A review of client			
		sion exam indicated the			
	•	ribed eyeglasses to wear			
	due to backgroui	nd diabetic eye disease.			
	An intomious	th the group home			
		th the group home al Nurse (LPN) was			
		31/12 at 11:20 A.M The			
		lient #3's eyeglasses were			
	"probably sent o				
	producty scrit o	at 101 10puii.			
	9-3-7(a)				
	( <del></del> )				
l			1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G806		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  08/31/2012		
NAME OF P	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/01/	2012
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Based on observing facility failed to practices and precontamination, dadministration, #1, #2, #3, #4 and medications were containers onto the put in each frindings included A morning observing facility failed to practices and precontamination, dadministration, #1, #2, #3, #4 and medications were containers onto the put in each frindings included A morning observing facility failed to practices and precontainers onto the put in each frindings included A morning observing failed from the group home of A.M. until 8:15 A.D. Direct Support Program administer medications. Direct failed from the put in each failed from the group home of the	active program for the ol, and investigation of amunicable diseases.  ation and interview, the maintain proper hygiene event cross uring medication for 5 of 5 clients (client d #5) whose oral e popped out of the he staff's bare hands and client's bare hands.  :  vation was conducted at on 8/28/12 from 5:40 A.M At 6:40 A.M., professional (DSP) #1	Wo	TAG	CROSS-REFERENCED TO THE APPROPRIA	ll re tor rse e	
	DSP #1 popping onto their bare ha						
	At 6:45 A.M., D	irect Support					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		15G806	B. WIN			08/31/	/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R			OODLAWN		
ARC OF	NORTHWEST IND	IANA INC, THE		1	TH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	FIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Professional (DS	SP) #1 began					
	administering client #1's medications.						
	DSP #1 popped each of client #1's						
	medications onto his bare hands and then						
	placed each on into client #1's bare hands						
		and then instructed client #1 to take his					
		medications. Client #1 and DSP #1 did					
		not wash their hands prior to DSP #1					
		_					
	popping client #1's medications onto their						
	bare hands.						
	At 6:50 A.M., Direct Support						
		• •					
	Professional (DS	, •					
		ient #4's medications.					
		each of client #4's					
	medications onto	o his bare hands and then					
	placed each on in	nto client #4's bare hands					
	and then instruct	ted client #4 to take his					
	medications. Cl	ient #4 and DSP #1 did					
	not wash their ha	ands prior to DSP #1					
		4's medications onto their					
	bare hands.						
	oure names.						
	At 6:55 A.M., D	rirect Support					
	Professional (DS	• •					
	`	ient #3's medications.					
		each of client #3's					
		o his bare hands and then					
	placed each on into client #3's bare hands						
	and then instructed client #3 to take his						
	medications. Client #3 and DSP #1 did						
		ands prior to DSP #1					
	popping client #	3's medications onto their					
	bare hands.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G806			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/31/2012
	PROVIDER OR SUPPLIEI NORTHWEST IND		1441 W	ADDRESS, CITY, STATE, ZIP CODE OODLAWN TH, IN 46319	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	DSP #1 popped medications onto placed each on it and then instruct medications. Clark not wash their has popping client # bare hands.  An interview with Licensed Practice conducted on 8/LPN indicated washed his hand prompted clients.	SP) #1 began ient #5's medications. each of client #5's to his bare hands and then into client #5's bare hands ted client #5 to take his ient #5 and DSP #1 did ands prior to DSP #1 5's medications onto their th the group home eal Nurse (LPN) was 30/12 at 1:45 P.M The DSP #1 should have ls and should have s #1, #2, #3, #4 and #5 to s prior to administering			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
	15G806				08/31/	2012
DOWIDED OD CLIDDLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
ROVIDER OR SUPPLIER			1441 W	OODLAWN		
		GRIFFITH, IN 46319				
		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
`				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
	LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCY		DATE
DINING AREAS AThe facility must e chairs, eating uter to meet the devel client.	equip areas with tables, nsils, and dishes designed opmental needs of each	W0	484	staff on active treatment, family style dining guidelines and me	y	09/20/2012
facility failed for #2, #3, #4 and #5	5 of 5 clients (clients #1, 5) living in the group			compliance, Service Coordinate will observe at least one meal	tor	
home to provide condiments and butter knives at the dining table.  Findings include:					st	
				bi-monthly thereafter.		
the group home of A.M. until 8:15 A clients #1, #2, #3 which consisted sausage and toas substitute, peppe butter knives on	on 8/28/12 from 5:40 A.M At 7:45 A.M., B, #4 and #5 ate breakfast of scrambled eggs, t. There was no salt/salt or, butter, jelly, ketchup or the table available for					
Coordinator (SC 8/31/12 at 10:50 condiments and l	) was conducted on A.M The SC indicated knives should be put on					
(	SUMMARY S' (EACH DEFICIEN REGULATORY OR 483.480(d)(3) DINING AREAS A The facility must chairs, eating ute to meet the devel client.  Based on observing facility failed for #2, #3, #4 and #3 home to provide knives at the diministration of the group home of A.M. until 8:15 A clients #1, #2, #3 which consisted sausage and toas substitute, pepper butter knives on clients #1, #2, #3  An interview with Coordinator (SC 8/31/12 at 10:50 condiments and the table for the consistence of the consistence of the condiments and the table for the consistence of the condiments and the table for the consistence of the condiments and the table for the consistence of the condiments and the table for the condiments and table for the con	IDENTIFICATION NUMBER: 15G806  ROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.480(d)(3)  DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.  Based on observation and interview, the facility failed for 5 of 5 clients (clients #1, #2, #3, #4 and #5) living in the group home to provide condiments and butter knives at the dining table.  Findings include:  A morning observation was conducted at the group home on 8/28/12 from 5:40  A.M. until 8:15 A.M At 7:45 A.M., clients #1, #2, #3, #4 and #5 ate breakfast which consisted of scrambled eggs, sausage and toast. There was no salt/salt substitute, pepper, butter, jelly, ketchup or butter knives on the table available for clients #1, #2, #3, #4 and #5's use.  An interview with the Service Coordinator (SC) was conducted on 8/31/12 at 10:50 A.M The SC indicated condiments and knives should be put on the table for the clients to use at all meals.	ROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.  W0.  Based on observation and interview, the facility failed for 5 of 5 clients (clients #1, #2, #3, #4 and #5) living in the group home to provide condiments and butter knives at the dining table.  Findings include:  A morning observation was conducted at the group home on 8/28/12 from 5:40 A.M. until 8:15 A.M At 7:45 A.M., clients #1, #2, #3, #4 and #5 ate breakfast which consisted of scrambled eggs, sausage and toast. There was no salt/salt substitute, pepper, butter, jelly, ketchup or butter knives on the table available for clients #1, #2, #3, #4 and #5's use.  An interview with the Service Coordinator (SC) was conducted on 8/31/12 at 10:50 A.M The SC indicated condiments and knives should be put on the table for the clients to use at all meals.	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  ROUTHWEST INDIANA INC, THE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.480(d)(3)  DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.  W0484  Based on observation and interview, the facility failed for 5 of 5 clients (clients #1, #2, #3, #4 and #5) living in the group home to provide condiments and butter knives at the dining table.  Findings include:  A morning observation was conducted at the group home on 8/28/12 from 5:40  A.M. until 8:15 A.M At 7:45 A.M., clients #1, #2, #3, #4 and #5 ate breakfast which consisted of scrambled eggs, sausage and toast. There was no salt/salt substitute, pepper, butter, jelly, ketchup or butter knives on the table available for clients #1, #2, #3, #4 and #5's use.  An interview with the Service Coordinator (SC) was conducted on 8/31/12 at 10:50 A.M The SC indicated condiments and knives should be put on the table for the clients to use at all meals.	DETIFICATION NUMBER: 15G806  ROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.480(d)(3)  DINING AREAS AND SERVICE  The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.  Based on observation and interview, the facility failed for 5 of 5 clients (clients #1, #2, #3, #4 and #5) living in the group home to provide condiments and butter knives at the dining table.  Findings include:  A morning observation was conducted at the group home on 8/28/12 from 5:40  A.M. until 8:15 A.M At 7:45 A.M., clients #1, #2, #3, #4 and #5 ate breakfast which consisted of scrambled eggs, sausage and toast. There was no salt/salt substitute, pepper, butter, jelly, ketchup or butter knives on the table available for clients #1, #2, #3, #4 and #5's use.  An interview with the Service Coordinator (SC) was conducted on 8/31/12 at 10:50 A.M The SC indicated condiments and knives should be put on the table for the clients to use at all meals.	ROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEPICIENCY MUST BE PRECEDED BY FULL REQUIRED MAN ABJORAN AS A ABJORAN SOME AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.  Based on observation and interview, the facility failed for 5 of 5 clients (clients #1, #2, #3, #4 and #5) living in the group home to provide condiments and butter knives at the dining table.  Findings include:  A morning observation was conducted at the group home on 8/28/12 from 5:40  A.M. until 8:15 A.M At 7:45 A.M., clients #1, #2, #3, #4 and #5 at breakfast which consisted of scrambled eggs, sausage and toast. There was no salt/salt substitute, pepper, butter, jelly, ketchup or butter knives on the table available for clients #1, #2, #3, #4 and #5's use.  An interview with the Service  Coordinator (SC) was conducted on 8/31/12 at 10:50 A.M The SC indicated condiments and knives should be put on the table for the clients to use at all meals.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 08/31/2012	
	PROVIDER OR SUPPLIE		1441 W	ADDRESS, CITY, STATE, ZIP CODE /OODLAWN TH, IN 46319	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G806	B. WIN			08/31/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	PROVIDER OR SUPPLIER				OODLAWN		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0488		assure that each client eats istent with his or her	Wo	488	See W 484		09/20/2012
	facility failed to living in the group #3, #4 and #5) pareparation and friendings include  A morning observation the group home of A.M. until 8:15 A.D. Direct Support P. Dire	rvation was conducted at on 8/28/12 from 5:40 A.M At 7:10 A.M., professional (DSP) #1 ggs, sausage and toast, as 3, #4 and #5 sat in the a no activity. At 7:45 acced already prepared ing table where clients d #5 sat with no activity. 3, #4 and #5 did not eparation and did not 5.					
		capable of participating					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G806		A. BUILDING	00 	COMP	COMPLETED  08/31/2012	
		100000	B. WING	ADDRESS, CITY, STATE, ZIP CO		1/2012
	ROVIDER OR SUPPLIER NORTHWEST INDI		STREET A 1441 W GRIFFI	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	themselves.					
	themselves. 9-3-8(a)					

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